



## Rapid development of osteoarthritis following arthroscopic resection of an “os acetabuli” in a mildly dysplastic hip—a case report

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## Correspondence

### Rapid development of osteoarthritis following arthroscopic resection of an “os acetabuli” in a mildly dysplastic hip—a case report

*Sir*—We read with interest the article in the June issue of *Acta Orthopaedica* by Cuéllar et al. (2015). We would like to make some comments regarding the radiographs and the interpretation and the treatment following the interpretation.

Firstly, an error must have happened with the radiographs and the inserted angle measurements in Figure 1A. The lateral center edge angle (LCE) should use the center of the head as reference point, and the Tönnis angle (Acetabular Index) should use the proximal edge of the acetabular fossa as reference point.

Secondly, the authors present the joint as mildly dysplastic with a LCE of 15°. We agree that the measurement should not include the os acetabuli, as this fragment does not contribute to the hip joint stability. We find the hip joint presented to be severe dysplastic.

Thirdly, we find signs of severe osteoarthritis with sclerosis of the acetabular roof, a large bone cyst in the acetabular roof and also apparently signs of degenerative changes in the femoral head. There are at least Tönnis grade 2 arthritic changes in Figure 1A, and therefore a hip arthroscopy should not be performed.

Fourthly, the authors compare this case with 3 other cases of iatrogenic instability after hip arthroscopy. As we see this case there was already significant instability at the time of arthroscopy and arthritis as a result of this.

We therefore find that the arthroscopy should never have been performed due to ongoing moderate arthritis and severe dysplasia. A total hip replacement instead should have been the surgery of choice. The advanced arthritic changes also excludes a periacetabular osteotomy (PAO).

We believe that conservative surgical treatment (arthroscopy or PAO) should only be offered patients with none or only a mild degree of osteoarthritis (Tönnis grade 0–1) and in our departments we consider arthroscopy as contraindicated in patients with dysplasia (CE <25°) since the osseous abnormality present in dysplasia should be corrected by performing a PAO.

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*Sir*—We would like to thank Kraemer and Søballe for their enriching comments about our case report (Cuéllar et al. 2015).

We completely agree about the error in Figure 1A, a mistake during the publishing process. We enclose a corrected version, please see Erratum on the following page.

We mentioned in our paper that this is a very controversial case. Indeed, that was the main motivation for publication. At least in Spain, many arthroscopists are in their learning curve, and with this case we tried to show 2 important aspects of the indication for arthroscopy: acetabular coverage and preoperative degenerative stage.

Regarding the degenerative stage, although the Tönnis classification is widely accepted, there is a variability between observers. In our case, the damage in the acetabular cartilage during hip arthroscopy was grade 2 in the Haddad classification (cleavage tear without delamination) and we observed no significant chondral lesions in the femoral head. Even accepting that it would be a Tönnis grade 2, clinical improvement after arthroscopy has been reported in half of patients with Tönnis grade 2 and 3 osteoarthritis for at least 2 years (Daivajna et al. 2015). We discussed carefully with the patient the different treatment options, including total hip replacement, and the patient accepted only hip arthroscopy as a surgical option.

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